

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01104

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PMS. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY SAINT MARY'S		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKVILLE		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE	
		f. STREET ADDRESS	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First	Middle
		MARIA	BANKINS
4. DATE OF DEATH JANUARY 1 1958		Month	Day
5. SEX FEMALE		6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH FEB. 4, 1873		9. AGE (in years last birthday) 84 yrs.	10. IF UNDER 14 YRS. Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WALLACE LEE		14. MOTHER'S MAIDEN NAME MARY EDWARDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	17. INFORMANT MRS. FLORINE FRANKLIN
		Address MECHANICSVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION (INTERVAL BETWEEN ONSET AND DEATH) Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROSIS IMMEDIATE (c) 10 YEARS (d) DEATH (e) DEATH (f) DEATH (g) DEATH (h) DEATH (i) DEATH (j) DEATH (k) DEATH (l) DEATH (m) DEATH (n) DEATH (o) DEATH (p) DEATH (q) DEATH (r) DEATH (s) DEATH (t) DEATH (u) DEATH (v) DEATH (w) DEATH (x) DEATH (y) DEATH (z) DEATH (aa) DEATH (bb) DEATH (cc) DEATH (dd) DEATH (ee) DEATH (ff) DEATH (gg) DEATH (hh) DEATH (ii) DEATH (jj) DEATH (kk) DEATH (ll) DEATH (mm) DEATH (nn) DEATH (oo) DEATH (pp) DEATH (qq) DEATH (rr) DEATH (ss) DEATH (tt) DEATH (uu) DEATH (vv) DEATH (ww) DEATH (xx) DEATH (yy) DEATH (zz) DEATH (aa) DEATH (bb) DEATH (cc) DEATH (dd) DEATH (ee) DEATH (ff) DEATH (gg) DEATH (hh) DEATH (ii) DEATH (jj) DEATH (kk) DEATH (ll) DEATH (mm) DEATH (nn) DEATH (oo) DEATH (pp) DEATH (qq) DEATH (rr) DEATH (ss) DEATH (tt) DEATH (uu) DEATH (vv) DEATH (ww) DEATH (xx) DEATH (yy) DEATH 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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1105

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb 43 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Agnes	Middle Violet	Last Bean	4. DATE OF DEATH	Month January	Day 7	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1895	9. AGE (in years lost birthday) yrs. 62	IF UNDER 1 YEAR Months 15	IF UNDER 24 HRS. Days 15	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Uriah Goodman Goodwin				14. MOTHER'S MAIDEN NAME Ellen Wood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John S. Bean		Address Ridge, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO Pneumonia with Convulsions } (c) DUE TO Chronic Nephritis						INTERVAL BETWEEN ONSET AND DEATH 2 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fracture of skull					
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 9, 1952 , to Jan. 7, 1958 , that I last saw the deceased alive on Jan. 7, 1958 , and that death occurred at 3:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city, or town, state) Leonardtown, Md. DATE SIGNED 1/10/58							
ACTUAL SIGNATURE Robert Fuchs		M.D.					
PHYSICIAN'S NAME (Type) Robert Fuchs M.D.		Leonardtown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/58		22c. NAME OF CEMETERY OR CREMATORIAL St. Michael's		22d. LOCATION (City, town, or county) Ridge, (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 13 '58	
						24b. REGISTRAR'S SIGNATURE Albert L. Fuchs	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Item 7 FilmG221 1-27-58 et

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Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown			c. LENGTH OF STAY IN 1b D.O.A.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Leonardtown		
3. NAME OF DECEASED (Type or print) William Spray Beauchamp			4. DATE OF DEATH Month January Day 20 , Year 1958		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 26, 1895		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Beauchamp			14. MOTHER'S MAIDEN NAME Cecilia Cattin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-24-8933		17. INFORMANT Address Wilbert F. Beauchamp 4400 Walker Rd., Charlotte, North Carolina	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH immediate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE William D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William D. Boyd M.D.		DATE SIGNED 1/21/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/58		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln	
22d. LOCATION (City, town, or county) B201 Bladensburg Rd, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 11th St. S.E. Washington,		ADDRESS DATE: 1/24/58		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Quinton	

OF BROWNSVILLE INTO BROWNSVILLE AND STANISLAVSKY
HEADED TO STADTMUER'S "BROWNSVILLE JAZZ BAND".

BUREAU V. S.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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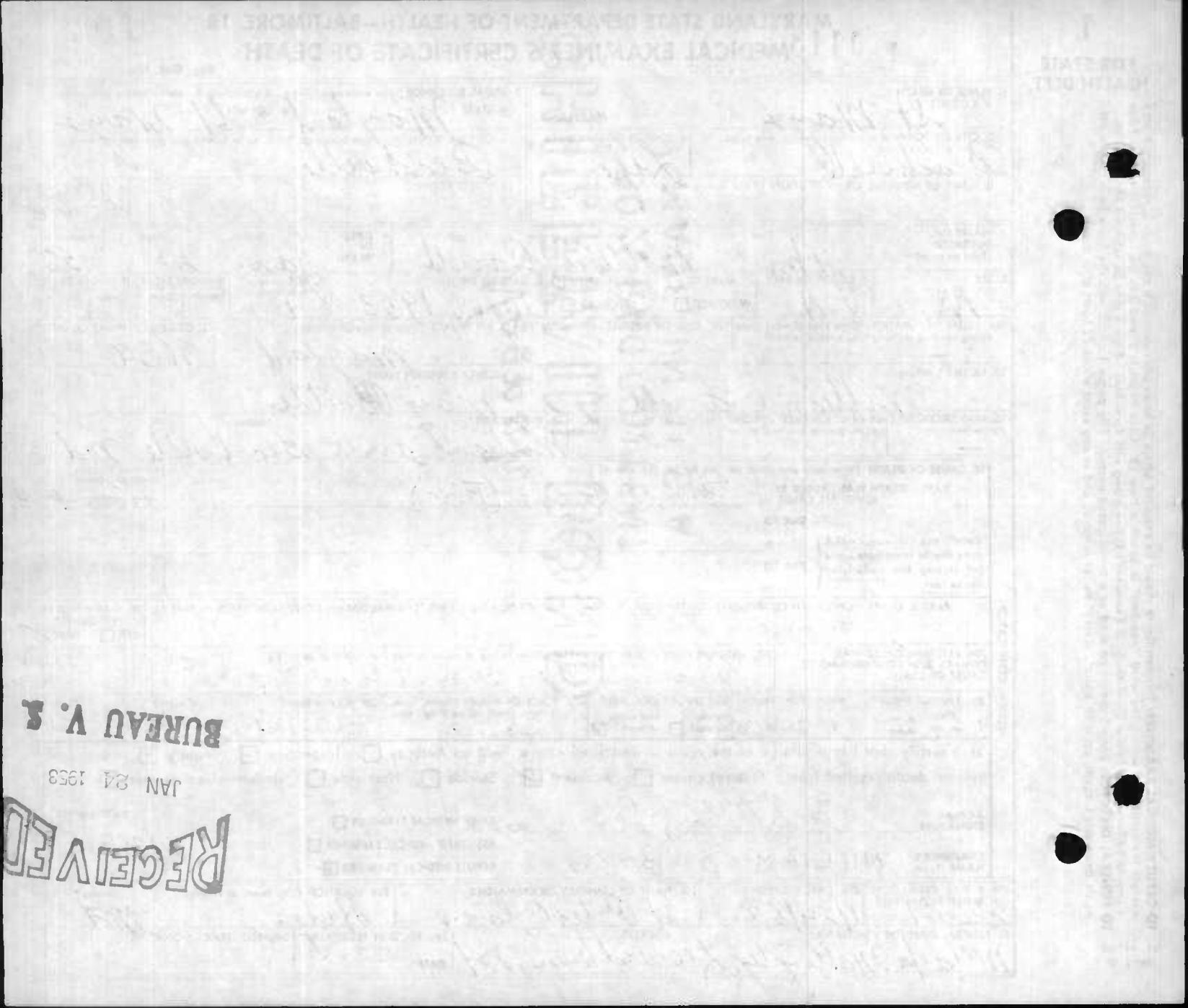
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>St Mary's</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St Mary's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beachville</i>		c. LENGTH OF STAY IN lb <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John</i>		First <i>John</i>	Middle <i>Wayne</i>
4. DATE OF DEATH Month <i>Jan.</i> Day <i>22</i> Year <i>1958</i>		5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 8, 1953</i>	
9. AGE (In years last birthday) <i>4 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Carroll</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Butler</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>William Carroll Beachville, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Burns Severe (Fire)</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Deceased was burned to death when fire broke out in his</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>9:44</i> a.m. <i>1 22 1958</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Beachville St Mary's Md</i> (County) <i>St Mary's</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>WILLIAM D BOYD</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22c. DATE THEREOF <i>1/24/58</i>	
22d. NAME OF CEMETERY OR CREMATORIAL <i>St Peter Claver</i>		22d. LOCATION (City, town, or county) <i>Bridge</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clark Mattingly</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 24 '58</i>	
ADDRESS <i>Leonardtown, Md.</i>		24b. REGISTRAR'S SIGNATURE DATE <i>Feb 24 '58</i>	

RECEIVED

BUREAU V. S.

JAN 24 1953



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	St. Mary's	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	Md	b. COUNTY	St. Mary's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Piney Point	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Piney Point	d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Doy	Year
James Steven Clayton				JAN	29	1958	

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years from birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Male	Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/6/1957	1	Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Ralph Clayton	Margaret Rosalee Lawrence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
—	—	George R. Clayton - Piney Point, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 491X		2 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b)		
DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
--	--	--	--	--	--	--

ACTUAL SIGNATURE	Alasdair Boyd M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
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EXAMINER'S NAME (Type)	W. D. Boyd M. D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	1/29/58
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22a. BURIAL, CREMATION, REMOVAL, (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	1-31-58	St Francis Xavier	St George Island, Md

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
W. Clarke Halligan, Jr., Leonardtown, Md.		JAN 31 '58	Quinton

WISCONSIN STATE DEVELOPMENT BOARD - SATURDAY, 10
JULY 1958 EXAMINER CERTIFICATE OF DATA

BUREAU V. 5

JUN 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01109

1115

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dr. Office		e. STREET ADDRESS Rural	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle Floyd	Last Downes, Jr.
4. DATE OF DEATH	Month Jan.	Day 10	Year 19 58
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 4. 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James F. Downes, Sr.	
14. MOTHER'S MAIDEN NAME Hazel Nations		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. -----		17. INFORMANT James F. Downes, Sr. - Mechanicsville, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO 491X		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred while at work	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 9th , 1958, to Jan 10th , 1958, that I last saw the deceased alive on Jan 10th , 1958, and that death occurred at 11 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Leonardtown MD. DATE SIGNED Charles Greenwell MD. 2nd	
ACTUAL SIGNATURE CHARLES GREENWELL		PHYSICIAN'S NAME (Type) CHARLES GREENWELL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph Cemetery
22d. LOCATION (City, town, or county) Morganza, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE JAN 15 '58	24b. REGISTRAR'S SIGNATURE Albert Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
JAN 15 1968				
BUREAU V. S.				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1116

CERTIFICATE OF DEATH

01110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Valley Lee	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First William	Middle Joseph	Last Eberle	4. DATE OF DEATH Month Jan. Day 28, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1957	9. AGE (In years lost birthday) yrs. 3 Months 1 Days	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Warren Francis Eberle			14. MOTHER'S MAIDEN NAME Margaret Ann Moore		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Warren F. Eberle Valley Lee, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute overwhelming infection probably pneumonia INTERVAL BETWEEN ONSET AND DEATH 12 hrs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) (State) -----
21. I certify that I attended the deceased from Oct 27, 1957 to Jan 28, 1958 , that I last saw the deceased alive on Jan 31, 1958 , and that death occurred at ----- M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md DATE SIGNED -----					
ACTUAL SIGNATURE J. Roy Guyther M.D.			PHYSICIAN'S NAME (Type) Mechanicsville, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-30-58	22c. NAME OF CEMETERY OR CREMATORIUM St. Alloysius	22d. LOCATION (City, town, or county) Leonardtown, Maryland (State) -----		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.			24a. REG'D BY REGISTRAR JAN 31 1958	24b. REGISTRAR'S SIGNATURE -----	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V.

JAN 31 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01111

1. PLACE OF DEATH o. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland		b. COUNTY St. Marys		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oraville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oraville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Stephen		First Leon	Middle Graves	Lost	4. DATE OF DEATH Jan. 11	Month 1958	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 16, 1874	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Stephen Graves		14. MOTHER'S MAIDEN NAME Martha Hayden						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mary L. Graves - Oraville, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Pyonephrosis - prostatic hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jan 10 1958						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mechanicsville, Md.		(County) (State)
21. I certify that I attended the deceased from Jan 10 1958 , to Jan 11 1958 , that I last saw the deceased alive on Jan 10 1958 , and that death occurred at Mechanicsville, Md. from the causes and on the date stated above. ACTUAL SIGNATURE J. Roy Guyther M.D. ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED								
PHYSICIAN'S NAME (Type) J. Roy Guyther, MD Mechanicsville, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph Cemetery		22d. LOCATION (City, town, or county) Morganza, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 15 '58		24b. REGISTRAR'S SIGNATURE A. Schenck		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

BUREAU X. E.

JAN 15 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01112

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oaksville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oaksville		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Gray	4. DATE OF DEATH January 14, 1958
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1869
9. AGE (In years last birthday) 88 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Henry Gray	14. MOTHER'S MAIDEN NAME Rebecca Unknown	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT Mrs Mable Suter	Address Mechanicsville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>W.D. Boyd</i>	DATE SIGNED 1/14/58		
EXAMINER'S NAME (Type) William D. Boyd M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/16/58	22c. NAME OF CEMETERY OR CREMATORIUM Galilee	22d. LOCATION (City, town, or county) Oaksville, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.	ADDRESS	24a. REC'D BY REGISTRAR JAN 20 '58 DATE	24b. REGISTRAR'S SIGNATURE <i>John E. Smith</i>

MANUFACTURED STATE DEPARTMENT OF HAWAII - BUREAU OF
TELEGRAPHIC GOVERNMENT CERTIFICATE OF DEATH

BUREAU X.

AN 20 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01113

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH o. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River		c. LENGTH OF STAY IN 1b 2 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X USNAS, Patuxent River	
3. NAME OF -DECEASED (type or print) Richard Homer HART		f. STREET ADDRESS 902-B, MOQ	
4. DATE OF DEATH January 14 1958	Month January	Day 14	Year 1958
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1919
9. AGE (In years last birthday) 36 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Aviator	11. KIND OF BUSINESS OR INDUSTRY U.S. Navy	12. BIRTHPLACE (State or foreign country) Louisiana
13. FATHER'S NAME S. M. HART	14. MOTHER'S MAIDEN NAME Esther Payne		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 3/41 to 1/58	17. INFORMANT Official Navy Records	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Laceration of Brain
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 860 X		INTERVAL BETWEEN ONSET AND DEATH Immediately	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO		(b) Skull Fracture	
		(c) Trauma	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Laceration of spinal cord			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft (instrument) landing explosion		
20c. TIME OF INJURY Hour o. m. 8:21 AM Jan 14 1958	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods	20f. (City or town) USNAS, St. Mary's, Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Paul Levine</i>		DATE SIGNED 14 January 1958	
EXAMINER'S NAME (Type) WM. D. BOYD, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 17, 1958	22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) ARLINGTON (State) VA.
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY	ADDRESS LEONARDTOWN, MD.	24a. REC'D. BY REGISTRAR JAN 20 1958	24b. REGISTRAR'S SIGNATURE W. Clarke

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Answers

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G224 1-27-58 et

01114

1120

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood	
3. NAME OF DECEASED (Type or print) James King Heard		First James	Middle King
Last Heard		4. DATE OF DEATH January 14, 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH August 11, 1887
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	9. AGE (In years at birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Dent Heard		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-24-1887	17. INFORMANT Rosie C. Heard
		Address Hollywood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1954 to Jan 14, 1958 , that I last saw the deceased alive on Jan 13, 1958 , and that death occurred at 9 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtown, Maryland			
ACTUAL SIGNATURE William D. Boyd M.D. M.D.			
DATE SIGNED 1/14/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/58	22c. NAME OF CEMETERY OR CREMATORIUM St. John's
22d. LOCATION (City, town, or county) Hollywood, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR JAN 20 '58	24b. REGISTRAR'S SIGNATURE Reed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by hospital or attending physician. After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1121

CERTIFICATE OF DEATH

Reg. Dist. No.

01115

1. PLACE OF DEATH o. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Leonardtown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hosp.		X St. Georges Island d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) Eugene		First ----- Middle -----	4. DATE OF DEATH Month Day Year Henderson Jan. 17 19 58
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Oct. 2, 1883	9. AGE (In years lost birthday) 74 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea Food	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Edward Henderson		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	17. INFORMANT Queenie J. Henderson - Address St. Georges Island, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arterio Sclerotic Heart Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mo. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Thrombophilia g RT Fej.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 1957 to 17 Jan. 1958, that I last saw the deceased alive on Jan. 1958, and that death occurred at M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) R. L. Rehm Lexington Park, Md. DATE SIGNED 19 Jan 58	
ACTUAL SIGNATURE Ernest D. Rehm		PHYSICIAN'S NAME (Type) Ernest D. Rehm Lexington Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Georges Methodist
22d. LOCATION (City, town, or county) St. Georges Island, Md. (State)		24a. REC'D BY REGISTRAR	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson — Leonardtown, Md.		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	
AGE	
SEX	
ADDRESS	
NAME AND ADDRESS OF PHYSICIAN	
NAME AND ADDRESS OF FUNERAL DIRECTOR	
TIME AND PLACE OF DEATH	
CAUSE OF DEATH	
METHOD OF DEATH	
TIME OF DEATH	
TIME OF ISSUANCE	
SIGNATURE	

BUREAU V.

JAN 21 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01116

Reg. Dist. No.

1122

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X USNAS, Patuxent River	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Great Mills, Md.		c. LENGTH OF STAY IN lb 1 1/2 yrs.		d. STREET ADDRESS NAS Annex, Qtrs I-9		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)							
3. NAME OF -DECEASED (Type or print)		First Timothy	Middle Joseph	Last KEANE, Jr.	4. DATE OF DEATH January 6, 1958	Month Day Year	Day Year
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1925	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviator		10b. KIND OF BUSINESS OR INDUSTRY USMC		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Timothy Joseph KEANE, Sr.		14. MOTHER'S MAIDEN NAME Not available					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 7-43 to 1-58		17. INFORMANT USNAS, Patuxent River, Md. Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage							
DUE TO (b) Basilar Skull Fracture							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jet aircraft explosion, in air.					
20c. TIME OF INJURY Month, Day, Year 1158 a.m. Jan 6 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In air		20f. (City or town) Rural (County) Great Mills, St. Mary's, Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
DATE SIGNED 6 Jan 1958							
ACTUAL SIGNATURE P. LEVINE, LT MC USNR, USNAS, Patuxent River, Md.							
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) W. D. BOYD MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Chambers, 1400 Chapin St. Washington, D.C.							
ADDRESS JAN 13 '58							
24a. REC'D BY REGISTRAR JAN 13 '58 24b. REGISTRAR'S SIGNATURE Alvarez							

BUREAU V. 2

JAN 13 1968

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01117

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, putting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River, Md.				c. LENGTH OF STAY IN lb 2 yr 2mo.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Zane	Middle Henry	Last KRENKE	4. DATE OF DEATH January 14	Month 19	Day 58
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 15, 1926	9. AGE (in years less birthday) 31 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Airman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George August Krenke				14. MOTHER'S MAIDEN NAME Helen Rose (?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 10/44 to 1/58 276 22 5832		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of Brain INTERVAL BETWEEN ONSET AND DEATH Immediately <i>860X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Skull Fracture							
(c) Trauma DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft (instrument) landing explosion.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:21 AM 14 Jan 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) Patuxent River, St. Mary's, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<i>Paul Levine</i> ACTUAL SIGNATURE PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MD.							
DATE SIGNED							
EXAMINER'S NAME (Type) WM. D. BOYD, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Jan. 20, 1958		22c. NAME OF CEMETERY OR CREMATORIAL RIVERVIEW		22d. LOCATION (City, town, or county) MARTIN'S FERRY, OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY				24a. REC'D BY REGISTRAR JAN 20 '58			
				24b. REGISTRAR'S SIGNATURE Albert Leach			

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01118

1124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fatuxent River		c. LENGTH OF STAY IN lb 2 5/12 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X USNAS, Patuxent River	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 913-A, MOQ		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Wally		First	Middle	Last	4. DATE OF DEATH Month Day Year JANUARY 14 1958
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1919	9. AGE (In years last birthday) 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Aviator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME W. W. LAMAR		14. MOTHER'S MAIDEN NAME Mary Clarke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 6/41 to 1-58		16. SOCIAL SECURITY NO. 224 52 6140		17. INFORMANT Official Navy Records USNAS, Patuxent River, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of Brain INTERVAL BETWEEN ONSET AND DEATH Immediately Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Skull Fracture Immediately DUE TO (c) Trauma					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Laceration of spinal cord					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft (Instrument) landing explosion.			
20c. TIME OF INJURY Month, Day, Year 8:21 a.m. Jan 14, 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods	
20f. (City or town) Patuxent River, St. Mary's, Md.		(County) USNAS		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
22. ACTUAL SIGNATURE PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MD. DATE SIGNED 14 January 1958					
EXAMINER'S NAME (Type) WM. D. BOYD, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22b. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		22c. DATE THEREOF JAN. 17, 1958		22d. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL	
22d. LOCATION (City, town, or county) ARLINGTON		(State) VA.			
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY LEONARDTOWN, MD.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 20 '58	
				24b. REGISTRAR'S SIGNATURE Q. E. Seach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED - EXAMINER'S CERTIFICATE OF GENUINENESS
FEDERAL BUREAU OF INVESTIGATION - WASHINGTON, D. C.

BUREAU V. S.
JAN 20 1953
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01119

Item 20 Film 225 1-21-28 a.m.s

Reg. Dist. No.

1125

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director; Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial/transit, or removal.

1. PLACE OF DEATH a. COUNTY ST. MARY'S		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLTON POINT		b. COUNTY St Mary's	
c. LENGTH OF STAY IN lb 26 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colton Point	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle ADELBERT	Last LEE
4. DATE OF DEATH	Month JANUARY	Day 17	Year 19 58
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1878
9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LAWYER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) NEW YORK	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ADELBERT H. LEE	14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT ADELBERT W. LEE.	Address 3211 PENNSYLVANIA AV. WASHINGTON D.C.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OLD + RECENT MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 917.0 DUE TO Candidias, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BURNS OF BUTTOCKS + THIGHS			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned when he backed into stove		
20c. TIME OF INJURY Hour a. m. ? p. m. 1/7/58 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Colton Point St. Marys Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Paul F. Guerin</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>Paul F. Guerin</i>
EXAMINER'S NAME (Type) PAUL F. GUERIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-20-58	22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL	22d. LOCATION (City, town, or county) SUITLAND
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Guerin</i>		ADDRESS <i>Colton Point Home - Black</i>	24a. REC'D BY REGISTRAR DATE JAN 22 '58
			24b. REGISTRAR'S SIGNATURE <i>Paul F. Guerin</i>

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BUREAU Y. S.
JAN 22 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01120

Reg. Dist. No.

1126

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River		c. LENGTH OF STAY IN 1b 10 mos.		a. STATE Maryland b. COUNTY St. Mary's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lexington Park	
				d. STREET ADDRESS 154 W. Rennel	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print) Edward Reynold LIBERDA		First	Middle	Last	4. DATE OF DEATH January 14, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec 29, 1926	9. AGE (in years last birthday) 31 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Airman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Theodore H. Liberda			14. MOTHER'S MAIDEN NAME Louise (?)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <i>If yes, give war or dates of service</i> 2/44 to 1/58			16. SOCIAL SECURITY NO. 502 16 2859		17. INFORMANT Official Navy Records USNAS, Patuxent River, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive, Severe Burns		Immediately
860 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fire		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft (instrument) landing explosion		
20c. TIME OF INJURY Hour o. m. 8:21 p.m.	Month, Day, Year Jan 14, 1958	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods
20f. (City or town) USNAS	(County) Patuxent River, St. Mary's, Md.	(State)	

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
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22. ACTUAL SIGNATURE PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MARYLAND				DATE SIGNED
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ACTUAL SIGNATURE <i>Paul Levine</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	14 January 1958
EXAMINER'S NAME (Type) WM. D. BOYD, M.D.				

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-22-58	22c. NAME OF CEMETERY OR CREMATORIAL Jamestown	22d. LOCATION (City, town, or county) North Dakota
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23. FUNERAL DIRECTOR'S SIGNATURE McClure Mattingly Leonardtown, Md.	ADDRESS	24a. REC'D. BY REGISTRAR DATE JAN 20 '58	24b. REGISTRAR'S SIGNATURE <i>Reg. Search</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - DIVISION OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

DECEASED PERSON
Name: **John H. Kelly**
Age: 42
Sex: Male
Color: Brown
Height: 5' 7 1/2
Weight: 165
Cause of Death: **Cardiac Arrest**
Time of Death: **10:30 P.M.**
Place of Death: **Hospital**
Name of Hospital: **St. Vincent's Hospital**
Address: **100 West 125th Street, New York City**
Name of Physician: **Dr. John J. O'Connor**
Address: **100 West 125th Street, New York City**

DECEASED PERSON
Name: **John H. Kelly**
Age: 42
Sex: Male
Color: Brown
Height: 5' 7 1/2
Weight: 165
Cause of Death: **Cardiac Arrest**
Time of Death: **10:30 P.M.**
Place of Death: **Hospital**
Name of Hospital: **St. Vincent's Hospital**
Address: **100 West 125th Street, New York City**
Name of Physician: **Dr. John J. O'Connor**
Address: **100 West 125th Street, New York City**

EXAMINER'S SIGNATURE: **John J. O'Connor**
EXAMINER'S NUMBER: **2051988** DATE: **Aug 11 1958** TIME: **8:30 P.M.**

BUREAU V. S.

AN 80 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1127

CERTIFICATE OF DEATH

1121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST. MARY'S		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		b. COUNTY ST. MARY'S	
c. LENGTH OF STAY IN 1b XXXX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURRY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle KELVIN	Last MILLS
4. DATE OF DEATH	Month january	Day 20	Year 19 58
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG. 23, 1957
9. AGE (In years last birthday) yrs. 4	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS. Days 28	Hours 8
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LAWRENCE SOMMERVILLE	14. MOTHER'S MAIDEN NAME LOUISE MILLS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---	16. SOCIAL SECURITY NO. ---	17. INFORMANT LOUISE MILLS	Address HURRY, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X <i>Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Leonardtown	20f. (City or town) (County) Leonardtown Maryland
21. I certify that I attended the deceased from 1/20 , 1958, to 1/20 , 1958, that I last saw the deceased alive on 10 AM , 1958, and that death occurred at 1005 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtown Maryland			
ACTUAL SIGNATURE <i>Charles Greenwell</i>	M.D.	DATE SIGNED <i>1/21/58</i>	
PHYSICIAN'S NAME (Type) DR. CHARLES GREENWELL MD.	LEONARDTOWN, MARYLAND		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-20-58	22c. NAME OF CEMETERY OR CREMATORIAL ST. ALOYSIUS	22d. LOCATION (City, town, or county) (State) LEONARDTOWN MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY	ADDRESS LEONARDTOWN, MD.	24a. REC'D BY REGISTRAR JAN 21 '58	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>

CERTIFICATE OF DEATH

Date of Birth

JAN 21 1953

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 103746

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

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1. PLACE OF DEATH a. COUNTY St. Mary's Potomac River MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Richmond		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Off Raged Point		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warsaw 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS Rural		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Jesse	Middle Wallace	Last Mohler, Jr.	4. DATE OF DEATH Jan, Feb. 3 1958	Month Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/1928	9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Lexington, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Jesse W. Mohler, Sr.			14. MOTHER'S MAIDEN NAME Emma Barger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? no			16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Mary D. Mohler - Warsaw, Virginia		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8			INTERVAL BETWEEN ONSET AND DEATH immediate Drowning		
DUE TO Conditions, if any, which gave rise to immediate cause (b)					
(c) DUE TO (d) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) none					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) returning from duck blind, boat over turned,		
20c. TIME OF INJURY Hour a.m. 9	Month, Day, Year 1/3/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) potomac river	20f. (City or town) off Raged Point, Va.	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Wm. D. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 3/29/58	
EXAMINER'S NAME (Type) Wm. D. Boyd, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/1/58	22c. NAME OF CEMETERY OR CREMATORIAL Stonewall Jackson Memorial	22d. LOCATION (City, town, or county) Lexington, Va.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.			24a. REC'D BY REGISTRAR APR 2 '58	24b. REGISTRAR'S SIGNATURE <i>Out. 51</i>	
			DATE		

RECEIVED
APR 2 1968

BUREAU V. S.

WEDDING EXAMINER'S CERTIFICATE OF DEATH

STATE OF GEORGIA - DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1129 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11122

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, filling the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or remove.

1. PLACE OF DEATH a. COUNTY St. Mary's		b. CITY OR TOWN (If outside corporate limits, write RURAL USNAS, Patuxent River)		c. LENGTH OF STAY IN lb 4 mos.	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Bergen		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Little Ferry		d. STREET ADDRESS 31 Columbus Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. DATE OF DEATH January 14, 1958		Month	Day	Year			
3. NAME OF DECEASED (Type or print)	First Harry	Middle George	Last MORGAN, Jr.	4. DATE OF DEATH	Month	Day	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 9, 1933	9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Airman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry George Morgan, Sr.			14. MOTHER'S MAIDEN NAME Helen Irene (?)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 8/55 to 1/58 151 26 0305		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH Immediately	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive Severe Burns							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 860 X		DUE TO (b) Fire					
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft (instrument) landing explosion.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:21 a.m. Jan 14, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) USNAS (County) (State) Patuxent River, St. Mary's, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<i>Paul Levine</i> ACTUAL SIGNATURE PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MD.		DATE SIGNED 14 January 1958					
EXAMINER'S NAME (Type) WM. D. ROYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN, 20, 1958		22c. NAME OF CEMETERY OR CREMATORIUM LITTLE FERRY		22d. LOCATION (City, town, or county) (State) LITTLE FERRY NEW JERSEY	
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MD		24a. REC'D BY REGISTRAR DATE JAN 20 '58		24b. REGISTRAR'S SIGNATURE Dee. Leach	

RECEIVED - EXAMINER'S CERTIFICATE OF DEATH
NEW YORK STATE ATTORNEY GENERAL'S OFFICE

35

RECEIVED

(1) copy of death certificate

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BUREAU V.

JAN 20 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01123

1130

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements		
c. LENGTH OF STAY IN 1b 6 yrs.			d. STREET ADDRESS /		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) George Webster Owens			First	Middle	Last
4. DATE OF DEATH January 12, 1958			Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1866	9. AGE (In years last birthday) yrs. 91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Clements, Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Wilfred Owens			14. MOTHER'S MAIDEN NAME Mary Owens		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT J. Ernest Quade Clements, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown cause DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mechanicsville, Md.	20f. (City or town) Mechanicsville	(County) Md.
21. I certify that I attended the deceased from 1 Nov., 1957 to 12 Jan., 1958 that I last saw the deceased alive on 11 Jan., 1958 , and that death occurred at 1:30 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE David L. Mossman			ADDRESS (Street, city or town, state) Mechanicsville, Md.		
PHYSICIAN'S NAME (Type) David L. Mossman M.D.			DATE SIGNED 1/14/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/58	22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart	22d. LOCATION (City, town, or county) Bushwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.			24a. REC'D BY REGISTRAR Jan 15 '58	24b. REGISTRAR'S SIGNATURE DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JAN 15 1958

REFUGEE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate during the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1131 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Massachusetts	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River		c. LENGTH OF STAY IN 1b 2yr 1mo	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X St. Lawrence		d. STREET ADDRESS / 50 Congress St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vita		First Adam	Middle PAULAUSKAS
4. DATE OF DEATH January 14, 1958	Month January	Day 14	Year 58
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 4, 1927
9. AGE (In years last birthday) 30	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Airman	10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	11. BIRTHPLACE (State or foreign country) Massachusetts	
13. FATHER'S NAME Adam Paulauskas		14. MOTHER'S MAIDEN NAME Margaret (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] Yes		16. SOCIAL SECURITY NO. 10/45 to 1/58 033 14 2644	17. INFORMANT Official Navy Records
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns, Severe		INTERVAL BETWEEN ONSET AND DEATH Immediately	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 860X		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft (instrument) landing explosion.	
20c. TIME OF INJURY Hour 8:21		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods
Month, Day, Year a.m. Jan 14, 1959		20f. (City or town) USNAS	County (State) Patuxent River, St. Mary's, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Paul Levine</i>		DATE SIGNED 14 January 1958	
EXAMINER'S NAME (Type) Wm. D. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 20, 1958	22c. NAME OF CEMETERY OR CREMATORIUM LEONARDTOWN
22d. LOCATION (City, town, or county) BROCKTON,		(State) MASS.	
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY		24a. REC'D BY REGISTRAR DATE JAN 20 '58	
		24b. REGISTRAR'S SIGNATURE Asst. Secy.	

DEPARTMENT OF HOMELAND SECURITY
FEDERAL BUREAU OF INVESTIGATION

RECEIVED
FEB 1 1958
FBI - BOSTON
BOSTON, MASS.
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

BUREAU V. S.

JAN 20 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01125

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Missouri b. COUNTY Cooper	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River		c. LENGTH OF STAY IN lb 6 mos	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Booneville	
		d. STREET ADDRESS 403 3rd Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Larry Wayne RUDDER		First	Middle
		Last	
4. DATE OF DEATH January 14, 1958		Month	Day
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1937
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Airman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	11. BIRTHPLACE (State or foreign country) Missouri
13. FATHER'S NAME Marvine Brummal Rudder		14. MOTHER'S MAIDEN NAME Leona Frederica (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 6/55 to 1/58 495 36 7099	17. INFORMANT Official Navy Records
		12. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 860X		Laceration of Brain	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Immediately	
{ (b) Skull Fracture			
DUE TO (c) Trauma			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Laceration of spinal cord		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft (instrument) landing explosion	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:21 a.m. Jan 14, 1958		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods
		20f. (City or town) Patuxent River, St. Mary's, Md.	USNAS County (State) Patuxent River, St. Mary's, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 14 January 1958	
ACTUAL SIGNATURE <i>Paul Levine</i>		EXAMINER'S NAME (Type) WM. D. BOYD, M.D.	
EXAMINER'S NAME (Type) <i>Wm. D. Boyd, M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22o. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 20, 1958	22c. NAME OF CEMETERY OR CREMATORIUM BOONEVILLE
		22d. LOCATION (City, town, or county) BOONEVILLE	(State) MISSOURI
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MD.	24a. REC'D BY REGISTRAR DATE JAN 20 '58
			24b. REGISTRAR'S SIGNATURE <i>W. Clarke Mattingley</i>

MANUFACTURERS ARSENAL - BIRMINGHAM
MEDICAL EXAMINER'S OFFICE OF DEATH

George

Johnson

Wade

John

Boone

John

John

Boone

John

John

George

Johnson

Wade

John

George

Johnson

Wade

John

(1) Informant advised that he had been approached by a man who claimed to be a detective with the FBI. This man stated that he was investigating the death of a Negro in Birmingham.

Informant advised that he had no information concerning this matter.

Informant advised

Informant

Informant advised that he had no information concerning this matter.

BUREAU V. S.

JAN 20 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01126

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River		c. LENGTH OF STAY IN lb 1 yr 8mo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Floyd		First Olan	Middle TAYLOR
4. DATE OF DEATH January 14, 1958	Month Day Year	5. SEX Male	6. COLOR OR RACE Caucasian
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct 31, 1921	9. AGE (In years from birthday) 36 yrs.	10. IF UNDER 1 YEAR Months Days
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	11. BIRTHPLACE (State or foreign country) Alabama	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Airman	10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	11. CITIZEN OF WHAT COUNTRY? USA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Taylor	14. MOTHER'S MAIDEN NAME Velma Black	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 5/40 to 1/58	
16. SOCIAL SECURITY NO. 414 14 5006		17. INFORMANT Official Navy Records USNAS, Patuxent River, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture, Parietal and Frontal Skull, INTERVAL BETWEEN ONSET AND DEATH 860X			
DUE TO Depressed			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft (instrument) landing explosion.			
20c. TIME OF INJURY Hour 8:21	Month, Day, Year o. m. Jan 14 1958	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods
20f. (City or town) USNAS	20g. (County) Patuxent River, St. Mary's, Md.	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
22. ACTUAL SIGNATURE PAUL LEVINE, LT MC USNR, USNAS, PATUXENT RIVER, MD.			
DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W.M. D. BOYD, M.D.			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/20/58	22c. NAME OF CEMETERY OR CREMATORIUM Tell City	22d. LOCATION (City, town, or county) Tell City, Indiana
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.			
ADDRESS			
24a. REC'D BY REGISTRAR DATE JAN 20 '58			
24b. REGISTRAR'S SIGNATURE Alfred E. Deucher			

WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION OF
MEDICAL EXAMINERS

BUREAU V.

MAY 20 1958

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1134 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01127

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Michigan		b. COUNTY Genesee		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River		c. LENGTH OF STAY IN lb 9 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flint		d. STREET ADDRESS 59 x 3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 8049 Barden		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William		First	Middle "C"	Last THURAU	4. DATE OF DEATH January 14, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan 13, 1927	9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Airman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Stanley Tharau		14. MOTHER'S MAIDEN NAME Trene Christine (?)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 12/47 to 1/58 368 24 6298		17. INFORMANT Official Navy Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal Skull Fracture		INTERVAL BETWEEN ONSET AND DEATH Immediately				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 860 X		DUE TO (b)						
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft (instrument) landing explosion.						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8:21 p.m. Jan 14, 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) USNAS (County) (State) Patuxent River, St. Mary's, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
<i>Paul Levine</i> PAUL LEVINE, LT MC USNR, USNAS, Patuxent River, Md.								
ACTUAL SIGNATURE <i>Wm. D. Boyd</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 14 January 1958				
EXAMINER'S NAME (Type) WM. D. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-20-58		22c. NAME OF CEMETERY OR CREMATORIAL LEONARDTOWN		22d. LOCATION (City, town, or county) FLINT (State) MICHIGAN		
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN		24a. REC'D BY REGISTRAR JAN 20 '58		24b. REGISTRAR'S SIGNATURE <i>Albrecht</i>		

BUREAU V. A.

856 03 Nov 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1135

CERTIFICATE OF DEATH

01128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drayden		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Drayden	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Harold	Middle Aloysius
4. DATE OF DEATH		Month January	Day 14,
		Year 1958	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Male		Negro	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Aug. 27, 1957
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS. Days 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Warren Aloysius Young	
14. MOTHER'S MAIDEN NAME Bessie Ann Whalen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Bessie Ann Whalen Drayden, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Bronchitis - Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 25 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-14-58 , to 1-14-58 , that I last saw the deceased alive on 1-14-58 , 19 58 , and that death occurred at 1:45 A.M. M; from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Lexington Park, Md. DATE SIGNED 1-14-58	
ACTUAL SIGNATURE W.H. Patric		PHYSICIAN'S NAME (Type) W.H. PATRICK	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Mark's
22d. LOCATION (City, town, or county) Valley Lee,		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR JAN 20 '58	24b. REGISTRAR'S SIGNATURE Abb. Deane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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CERTIFICATE OF DEATH

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RECEIVED

BUREAU Y.

11129

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1136 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE	
St. Marys MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Leonardtown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
St. Marys Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
		Kenneth	E.
4. DATE OF DEATH		Month	Day
		Jan. 1,	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
		July 31, 57	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
none		none	Maryland
12. CITIZEN OF WHAT COUNTRY?		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Leonard D. Young		Iva Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
no		Leonard D. Young - Lexington Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 days	
492X		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
{		DUE TO	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 Dec., 1957, to Jan., 1957, that I last saw the deceased alive on 19, and that death occurred at 10:49 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Ernest D. Rehm		DATE SIGNED 2 Jan 57	
PHYSICIAN'S NAME (Type)		Ernest D. Rehm, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		1/2/58	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Ebenezer Cemetery		Great Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR	
		JAN 15 '58	
		24b. REGISTRAR'S SIGNATURE	
		Oliver Smith	

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CERTIFICATE OF DEATH

REGISTRY NO.	SEARCHED	INDEXED
SERIALIZED	FILED	RECORDED
DECEASED PERSON		
NAME		
ADDRESS		
AGE		
SEX		
MATERIAL TESTED		
TESTS		
CAUSE OF DEATH		
TIME AND PLACE OF DEATH		
DEATH CERTIFIED		
SIGNATURE		
STAMP		

BUREAU V. S.

APR 15 1953

RECEIVED